Destiny
RECOVERY & WELLNESS CENTRE
Rooted In Land and Spirit

CONTACT US
Phone: 1-877-250-HOPE
Email: info@destinywellness.ca
Fax: 1-431-815-4898

REFERRAL INFORMATION

Referring Workers Name:_____Phone Number:_____

Agency:_____

Address:_____ Email:_____

PERSONAL INFORMATION

Date:_____

Full Legal Name:_____ Preferred Name:_____

Date of Birth (MM/DD/YYYY):_____ PHIN # (9-digit):_____

Email:_____ Phone Number:_____

Address:_____ Treaty Number:_____
(if applicable)

Indigenous Affiliation:_____ Pronouns:_____

Languages Spoken:_____ Gender Identity:_____

Marital Status:_____ Ethnic Origin:_____

Employment History (list most recent positions and dates):

_____

_____

Education Level (last grade completed, further education):

_____

_____

EMERGENCY CONTACT

Emergency Contact Name:_____

Phone Number:_____ Relationship to Applicant:_____

FAMILY INFORMATION

Partner's Name (if applicable):_____

List all children's names, ages, and gender:

_____
_____
_____
_____

Current living situation of children. Are they with you, or have you made other arrangements?

_____
_____
_____
_____

Type of CFS order (VPA, Permanent, Temporary, Supervision):

_____
_____
_____
_____

Name of agency responsible for children in care:_____

Worker's name and contact info:_____

SUBSTANCE USE HISTORY

Drug Type	When did you start use?	Average dose per use:	How often:	Last use date:

MEDICAL & MENTAL HEALTH

Physician or Nurse Practitioner's name and contact info:

Name:_____ Phone Number:_____

Address:_____

Fax:_____ Email:_____

Currently pregnant? If yes, estimated due date:_____

Do you have any current or past medical conditions? If yes, please list, as well as any recent surgeries or hospitalizations with approximate dates.

_____
_____
_____
_____
_____

Please list all current medications:

_____
_____
_____

Please attempt to bring a two-week supply of medications in their original packages.

Do you experience suicidal ideation? Y / N

Have you ever attempted to take your own life? Y / N
If yes please describe briefly, with age, approximate date and circumstance

_____
_____
_____
_____

List any mental health diagnoses with date, name of Physician, and location:

_____
_____
_____
_____

Hospitalization history for mental health:

_____
_____
_____
_____

History of self-harm (unrelated to substance use):

_____
_____
_____
_____

TREATMENT HISTORY

Have you attended a treatment centre before? List name(s) and date(s) of other facilities attended:

_____
_____
_____
_____

Our treatment lengths starts at 30 days. There is also the option to attend for 45, 60, 90, and 120 days or longer if needed. How long do you estimate your stay will be? This can be changed as needed.

_____

LEGAL INFORMATION

Do you have a criminal record? If so please list details:

_____
_____
_____
_____

PAYMENT INFORMATION

Destiny Recovery & Wellness Centre is a private facility. This means that payment is required through one of the following options: Band or Treaty coverage, third-party insurance, or private payer. Please ensure arrangements are made prior to intake. Our team is available to assist with coordinating coverage if needed.

CONSENT & SIGNATURES

I understand that I may be required to provide a “Medical Clearance for Treatment” form before entry.

I consent to Destiny Recovery & Wellness Centre staff discussing my application with my referring agent (if applicable).

Applicant’s Signature:_____ Date:_____

STAFF USE ONLY

Is applicant suitable for placement? Yes / No

If not suitable, reason:

_____
_____
_____
_____
_____

Alternative services recommended:

_____
_____
_____
_____

Staff Signature:_____ Date:_____